

ILLINOIS DEPARTMENT OF PUBLIC AID
CHRONIC RENAL DISEASE PROGRAM

I, THE UNDERSIGNED, AUTHORIZE THE RELEASE OF ALL PREVIOUS MEDICAL RECORDS TO THE ILLINOIS DEPARTMENT OF PUBLIC AID OR THE APPROVED CHRONIC HEMODIALYSIS HOSPITAL PROGRAM.

FURTHER, IF I AM ACCEPTED, IT IS UNDERSTOOD THAT THE PROGRAM COVERS ONLY THOSE COSTS FOR CHRONIC DIALYSIS AND THAT COSTS FOR OTHER ILLNESS WILL NOT BE COVERED. PAYMENT FOR CARE MAY BE PROVIDED LIMITED BY THE APPROPRIATION MADE FOR THAT PURPOSE AND IN ACCORDANCE WITH POLICIES DEVELOPED BY THE ILLINOIS DEPARTMENT OF PUBLIC AID.

(Applicant's Signature)

(Parent or Guardian's Signature)

(Date)

(Witnessed By)